

Early Head Start - Child Daily Record

Parent/Guardian: _____

Site/Room #: _____

Child's Name: _____ Date: ____/____/____ Arrival time: _____

Parent's instruction or information: _____

Staff Signature: _____ Parent/Guardian Signature: _____ Departure Time: _____

Daily Routine

	Amount Eaten	Dialogue Engagement Time	Diapering		Nap	Medication Given		Mood: Happy, Crying, Quiet, Playful, etc.	Duration of Parent Involvement	Describe Specific Activity (Fingerplays, Songs, Transitions i.e., Pictures, objects, first and then statements)
			Urine	BM		Yes	No			
A.M Snack										
Formula/BRM/Milk										
Grain										
Fruit										
Breakfast										
Formula/BRM/Milk										
Cereal/Grain										
Fruit										
Lunch										
Formula/BRM/Milk										
Cereal/Grain										
Meat										
Fruit										
Vegetable										
Snack										
Formula/BRM/Milk										
Fruit/Juice										
Grain										
Meat										
BRM expiration date: _____ WCC: _____ Dental: _____ Lead: _____ Hgb: _____										Total Time for In-Kind